FILM No. G 109 APR 21 1947 -Evidence for addition of husband's name and birthdate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01133

1. PLACE OF DEATH (937)

County Kent Registration Dist. No. 200

Village or City Galena and No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Blanch T. Cochran If U. S. Veteran, specify WAR

(a) Residence: No. Galena and St., Ward. If nonresident give city or town and State

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James B. Cochran

6. DATE OF BIRTH (month, day, and year) Mar 1st 1846 ~~1847~~

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House work

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Md (State or country)

FATHER

13. NAME Benjman Sutton

14. BIRTHPLACE (city or town) Md. (State or country)

MOTHER

15. MAIDEN NAME Marie Thompson

16. BIRTHPLACE (city or town) Md (State or country)

17. INFORMANT Mrs. B. ~~Fenton~~ Towler (Address) Galena Md

18. BURIAL, CREMATION, OR REMOVAL Place Galena Cemetery Date 4/19/ 1947

19. UNDERTAKER G. Gates Caudell (Address) Townsend Del.

20. FILED April 18, 1947 Elizabeth J. Mulford Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April (Month) 16th (Day) 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from MARCH 28 1947, to APRIL 16 1947

I last saw her alive on April 16, 1947; death is said to have occurred on the date steted above, at 6.15 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
ARTERIO SCLEROTIC HEART DISEASE	1944
SENILITY	
GEN: ARTERIO SCLEROSIS	1930

Other Contributory Causes of Importance:

Emaciation	March 1947

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external ceuses (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or Injury in any wey related to occupation of deceased? No

If so, specify

(Signed) Theodore F. Paprocki M. D.

(Address) Galena, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

James B. Cochran

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

01134

Reg. Diat. No. 200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: (Hosp) Millington (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Millington Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clarence Comas

3.(b) Social Security Number: 157-03-4925

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Married

6.(b) Name of husband or wife: Sylvia Comas

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years	Months	Days	If less than one day
53 1894	~~Months~~	25	hrs. min.

9. Birthplace: Penn (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Cyrilla Comas

13. Birthplace: Penn

MOTHER — 14. Maiden name: Mary Chapman

15. Birthplace: Md

16. Informant: Sylvia Comas

Address: Millington Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4 1947 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Union Hill, Kent Co Md

18. Funeral director: Calvin Clark

Address: Town Line

19. April 30 1947 (Date rec'd by registrar) Edward Pellegrini Deputy Registrar

Page 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1947, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1947, to April 29 1947 and that I last saw him alive on April 27 1947

Immediate cause of death	DURATION
Diabetis Comas	1 day
Diabetis	10 years
Due to: Chr. Nephritis	
Due to: Pelvis	6 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Vincent Price M. D. or other

Address: Millington Md Date signed: 4/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

01135

CERTIFICATE OF DEATH

Reg. Dist. No. 200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Rural Millington
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insf. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Rural Millington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Emma Robson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widowed

6 (b) Name of husband or wife: James Robson
6(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): October — 1864

8. AGE: Years	Months	Days	If less than one day
82	7	—	hrs. min.

9. Birthplace: Kent Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Wm. Sharp
13. Birthplace: G.A. Co. Md.

MOTHER
14. Maiden name: Mary Jane Wyle
15. Birthplace: G.A. Co. Md.

16. Informant: Anna Stevenson
Address: Millington Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18-1947 (month) (day) (year)
Cemetery or crematory: Chesterville
Location: Chesterville Md.
18. Funeral director: Edgar L. Lane
Address: Church Hill Md.

19. April 17 1947 (Date rec'd by registrar) Edward Hellows Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14th 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6th 1947 to April 15th 1947, and that I last saw h[illegible] alive on April 13th 1947.

Immediate cause of death	DURATION
Apoplexy.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: G. L. Copeland M. D. or other
Address: Millington — Date signed April 15, 19[illegible]

01136

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 204

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Turner Station RD 2 Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Turner - Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eleanor Silverman Freeman

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widow

6.(b) Name of husband or wife: Harold Coleman Freeman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 3rd - 1870

8. AGE: Years: 76 | Months: 6 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Kent Co. Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Levin Freeman
13. Birthplace: Kent Co Md

MOTHER
14. Maiden name: Sarah Scott
15. Birthplace: Kent Co Md

16. Informant: Mrs Mallen

Address: Chestertown R F D No 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24th 47 (month) (day) (year)

Cemetery or crematory: Mt Hermon Farmers

Location: Farmers

18. Funeral director: Asbury Jones

Address: Chestertown RD No 1

19. April 24 1947 (Date rec'd by registrar) E N Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1947, at 9.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 5 1946, to April 10 1947, and that I last saw h[illegible] alive on April 10 1947

Immediate cause of death	DURATION
(a) Chronic Endocarditis	3 yrs
Due to (b) Congestive Heart Failure	
Arteriosclerosis	3 yrs
Due to (c)	
Other conditions: Rheumatic Arthritis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frederick Smith M. D. or other

Address: Chestertown Date signed: 4/22/47

01137

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
Kent and Queen Anne Co. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Infant Girl Gsell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7, 1947

8. AGE: Years	Months	Days	If less than one day
no	no	no	4 hrs. min.

9. Birthplace: Chestertown, Maryland
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: David W. Gsell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Miriam Smith
15. Birthplace: Maryland

16. Informant: David W. Gsell
Address: Chestertown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 8, 1947 (month) (day) (year)
Cemetery or crematory: Chester Cem.
Location: Chestertown, Md

18. Funeral director: J. Willis Wells
Address: Chestertown, Maryland

19. April 8, 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-7 19 47, at 11 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-7 19 47, to 4-7 19 47 and that I last saw h.. alive on 4-7 19 47

	DURATION
Immediate cause of death: Atelectasis	4 hours
Due to: Intracranial hemorrhage -	At least 4 hours
Due to: Trauma of labor after spontaneous rupture of amniotic sac.	20 hours.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. Ruth Barr M. D. or other
Address: Chestertown, Md Date signed 4-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (193)

01138

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown RD (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown RD md (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: James E. Hague
3.(b) Social Security Number: 215-26-4686

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Feb 6. 1923
8. AGE: Years 24 Months 2 Days 21 If less than one day ... hrs. ... min.
9. Birthplace: Rock Hall md (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business: Trucking & Freight
FATHER 12. Name: Elmer H. Hague
13. Birthplace: Rock Hall md
MOTHER 14. Maiden name: Blanche C. Perry
15. Birthplace: Rock Hall md
16. Informant: Blanche C. Perry Hague
Address: Rock Hall md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30-47 (month) (day) (year)
Cemetery or crematory: St. Paul
Location: Near Fairlee md
18. Funeral director: Edgar L. Lane
Address: Church Hill md
19. April 29 1947 (Date rec'd by registrar) Kathryn B. Fowler Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 1947, at 5:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Did not attend Investigated 19... to ... 19...
and that I last saw h... alive on ... 19...
Truck & signed certificate as Deputy Med. Exam. Kent
Immediate cause of death: Electrocuted — DURATION: Immediate
Due to: Driving truck run into electric pole
Due to: fell against live wire
Other conditions
(SEE OVER)
(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Apr 27/47
Where did injury occur: Chestertown RD Kent md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury: Electrocuted Injured at work? no
23. SIGNATURE: Frank Hines M.D. M.D. or other
Address: Chestertown md Deputy med. exam. Kent Co md
Date signed: Apr 29/47

"Subject tried to make curve at too high a speed, ran off on shoulder and knocked down light pole. No one was injured at this time. After it started to get light about 4.30 AM EST operator got out of truck to get help to pull out truck and walked into high tension line that had 13000 volts running thru it. Medical Examiner claimed subject was electrocuted and died immediately.

From report of M. V. Acc. - Com. of M.V. 7-26-47 ams

MARYLAND STATE DEPARTMENT OF HEALTH

01139

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Cannon St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary R. Jewell Hickman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Stephen B. Hickman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1861

8. AGE: Years	Months	Days	If less than one day
85	7	0	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Charles Jewell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mollie Pierce
15. Birthplace: Maryland

16. Informant: Mrs Elmer Reed
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13, 1947 (month) (day) (year)
Cemetery or crematory: Chester Cemetery
Location: Chestertown, Md.

18. Funeral director: J. Willis Wells
Address: Chestertown, Md.

19. April 11, 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1947, at 7.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1947, to April 10 1947
and that I last saw h[illegible] alive on April 9 1947

Immediate cause of death	Duration
Coma	1 Day
Due to: Carcinoma of breast face & neck	2 Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. G. Simpson M. D. or other
Address: Chestertown Date signed 4-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01140

CERTIFICATE OF DEATH

Reg. Dist. No. 200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Kent
City or town: Galena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Sassafras
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George C. Johnston

3.(b) Social Security Number: none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth data of deceased (mo., day, yr.): June 1, 1868
8. AGE: Years: 78 Months: Days: If less than one day: hrs. min.
9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
12. Name of father: John Johnston
13. Birthplace of father: Ireland
14. Maiden name of mother: Elizabeth Collison
15. Birthplace of mother: Scotland
16. Informant: George Johnston
Address: Rural Galena Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof: April 23 1947 (month) (day) (year)
Cemetery or crematory: Galena
Location: Galena Md.
18. Funeral director: Edward Fellows
Address: Millington Md.
19. April 23 1947 (Date rec'd by registrar) Elizabeth D. Telford Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20th 1947, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15th 1947, to April 20th 1947 and that I last saw h— alive on April 20th 1947

Immediate cause of death	DURATION
Asphyxia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. L. Copeland M. D. or other
Address: Melmyton Date signed: Apr 23 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164C

01141

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:
County: Kent
City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Raymond E. Shelton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel Shelton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 25 1904

8. AGE:

Years	Months	Days	If less than one day
42			hrs. ..... min.

9. Birthplace: Kent Md.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business
12. FATHER — Name: John O. Shelton
13. FATHER — Birthplace: Md.
14. MOTHER — Maiden name: Mary J. Maslin
15. MOTHER — Birthplace: Md.
16. Informant: Ethel Shelton
Address: Millington Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24 1947 (month) (day) (year)
Cemetery or crematory: Massey
Location: Massey Md
18. Funeral director: Edward Fellows
Address: Millington Md.
19. April 23 1947 (Date rec'd by registrar) Edward Fellows Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1947, at 11:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1947 to April 20 1947
and that I last saw h alive on April 19 1947
Immediate cause of death: (a) Deputy Med Examiner — DURATION
Due to: Suicide Gun Shot Wound Head
Due to: Rifle
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: None — Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Date of Apr 20/47
Accident, suicide, or homicide: Suicide
Where did injury occur? Millington (City or town) Kent (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Rifle — Injured at work? No
23. SIGNATURE: Isaac Med Examiner M. D. or other
Address: Chestertown Md. (Date signed) Apr 23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Kent & Queen Anne Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 339 Cabot St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Thomas.

3.(b) Social Security Number: 216-01-6438

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M.	C.	Married

6.(b) Name of husband or wife: Elvira Miller Thomas
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Oct. 31 1874

8. AGE: Years: 72 | Months: 5 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Nashville Tennessee (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: General

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Mrs. Elvira Miller Thomas
Address: 339 Cabot St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: apr. 8, 1947 (month) (day) (year)
Cemetery or crematory: Mongme Cemetery
Location: Mongme, Kent Co. Maryland

18. Funeral director: Maurice V. Williams
Address: Chestertown Md.

19. April 7 1947 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1947 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1946, to April 5 1947 and that I last saw him alive on April 5 1947

	DURATION
Immediate cause of death: Myocardosis	April
Due to: Arteriosclerosis	yrs.
Due to:	mo.
Other conditions: Pulmonary Edema	ds.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: N.D.W.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David Hamilton M.D. M. D. or other
Address: Chestertown Md. Date signed: Apr 7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01143

115C

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Kent

City or town: Kennedyville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Kennedyville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Same Below

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Lillian Virginia Tiller

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): (1899) Unknown

8. AGE: Years	Months	Days	If less than one day
About 48	—	—	hrs. min.

9. Birthplace: Kent Co Md (Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER — 12. Name: Joseph J Tiller

FATHER — 13. Birthplace: Kent Co

MOTHER — 14. Maiden name: Mary A Bowers

MOTHER — 15. Birthplace: Kent Co Md

16. Informant: Anna L Tiller

Address: Kennedyville md

17. Burial, cremation, or removal. Which?: Burial Date thereof: Apr 14 1947 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Still Pond

18. Funeral director: E R Fellows

Address: Still Pond Md

19. April 14 1947 (Date rec'd by registrar) J Welch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1947 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1947 to April 12 1947 and that I last saw h.. alive on April 12 1947

Immediate cause of death	DURATION
Thrombosis of Cerebral	
Due to	
Due to	
Other conditions: Paralysis of throat	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. P. Atwell M. D. or other

Address: Still Pond Date signed: 4/14/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-6)

CERTIFICATE OF DEATH

01144

Reg. Dist. No. 2022

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Worton R.D #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred: Butlertown

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Worton R.D #1

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Butlertown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mamie Elizabeth Wilson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	married

6.(b) Name of husband or wife: George M. Wilson

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): September 1 1893

8. AGE: Years	Months	Days	If less than one day
53	7	4	....hrs. ....min.

9. Birthplace: Quaker Neck Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER

12. Name: Henry Johnson

13. Birthplace: Quaker Neck Kent Co. Maryland

MOTHER

14. Maiden name: Lillie Mitchell

15. Birthplace: Quaker Neck Kent Co. Maryland

16. Informant: Mrs. George M. Wilson

Address: Worton R.D #1 Kent Co. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7 1947 (month) (day) (year)

Cemetery or crematory: Butlertown

Location: Butlertown - Worton Kent Co. Md.

16. Funeral director: Marion V. Williams

Address: Chestertown, Maryland.

19. April 7 1947 (Date rec'd by registrar) Clara L. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1947, at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1947, to April 5 1947

and that I last saw h...alive on 4-4 1947

Immediate cause of death	DURATION
Bronchopneumonia Sec. Thrush	
Due to: Septicemia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md. Date signed: 4/6/47